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ABSTRACT

This Kids Count report presents current information on adolescent pregnancy rates in Missouri. Part 1, "Overview of Adolescent Pregnancy in Missouri," discusses the changing pregnancy, abortion, and birth rates for 15- to 19-year-old adolescents, racial differences in pregnancy risk, regional differences suggesting a link between pregnancy and poverty, and the preponderance of adolescent births in urban counties. Part 2, "Risk Factors for Adolescent Pregnancy," discusses increasing teen sexual activity and contraceptive use; describes how the risk factors of poverty, high risk behavior, poor academic skills, media portrayal of sexuality, and sexual abuse can provide a basis for preventive strategies; and points out that positive relationships with family and church can reduce risk. Part 3, "Consequences of Adolescent Childbearing," illustrates the health, economic, and educational risks faced by adolescent mothers; discusses the disadvantages for children of teen parents; and presents the economic costs of teen pregnancy. Part 4, "Principles and Strategies to Reduce Adolescent Pregnancy," advocates programs targeting adolescent sexuality, contraceptive use, and pregnant or parenting teens, in addition to holistic programs addressing the underlying issues of poverty, unemployment, and school success. Part 5, "Selected Missouri Programs That Are Making a Difference," reveals that programs for pregnant or parenting teens were more common than prevention programs and that few programs had conducted outcome evaluations. Part 5 also describes several intervention programs. Appended are Missouri program contact persons, data notes, and acknowledgments. (Contains 26 references.) (KDFB)

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Is Parenting Child's Play?

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Kids Count in Missouri

Report on

Adolescent Pregnancy

Citizens for Missouri's Children

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Citizens for Missouri's Children is a statewide organization that serves as an independent voice for children on those issues, policies and government programs which affect their lives. CMC safeguards and promotes a better quality of life for our children. As a citizens' organization, CMC brings together the public and private sectors to develop more efficient and effective public services for children.

KIDS COUNT in Missouri is a four-year project sponsored by the Annie E. Casey Foundation to improve the well-being of Missouri's children. KIDS COUNT in Missouri increases the visibility of the condition of children and promotes policy and programmatic change through reports, advocacy, public education and community organization.

Adolescent Pregnancy

Is Parenting Child's Play?

KIDS COUNT in Missouri

A Report by Citizens for Missouri's Children

October 1994

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Is Parenting Child's Play? Adolescent Pregnancy in Missouri

ERRATA

The data for Hickory County were inadvertently omitted from the table on page 8. The data are:

# of Live births	13
Birth rate/1000	64.7
Rank	65
% Inadequate Prenatal Care	8.3
Rank	10
% Low birthweight	0
Rank	1
% Unmarried	46.2
Rank	24

Executive Summary

Adolescent pregnancy and childbirth are current issues of great concern to citizens and policymakers. It is popular to blame teen mothers for bleeding our public assistance system, spending our tax dollars and raising the next generation of drug addicts and criminals. Welfare "reform" ideas include requiring teens to live with their parents and reducing or eliminating their benefits. One "reformer" suggested removing children of teen parents and placing them in state-run orphanages. An examination of the realities of teen pregnancy show that these solutions are ill-conceived and inappropriate.

Adolescent pregnancy, while still a significant problem in Missouri, is showing signs of decrease. There were approximately 14,000 adolescent pregnancies and over 10,000 births in 1993. While sexual activity among adolescents has increased, contraceptive use has also risen. At least three-quarters of teens use contraceptives on an ongoing basis. As a result, the pregnancy rate among sexually active adolescents has actually decreased. However, only half use condoms, leaving many at risk for sexually transmitted diseases and HIV infection. The percent of teen pregnancies that end in abortion has decreased in the last ten years. Very few of the infants of adolescents are placed for adoption. Three-quarters of adolescents who give birth are not married.

Regionally, the counties with the highest rates of adolescent birth are located primarily in urban and southeast Missouri. Many of these counties also have high levels of child poverty, idle teens and high school dropouts.

There are clear risk factors for adolescent pregnancy, including poverty, poor academic skills and engaging in other high risk behaviors. Experiencing sexual abuse as an adolescent puts girls at higher risk for pregnancy. National studies indicate that a majority of girls who became sexually active before age 15 did so involuntarily.

Adolescent childbearing has serious consequences for both mother and child. Adolescent mothers face health risks, and are less likely to receive prenatal care or deliver a normal weight infant than older mothers. They are less likely to complete high school and more likely to be poor as adults. For far too many, there will be more than one pregnancy during their adolescent years. These repeat births, representing one-fourth of Missouri teen births, are an alarming sign that appropriate family and life planning services are not reaching adolescent parents. Children of adolescent parents start life at a disadvantage, with vulnerability to health problems, poverty, academic failure and early sexual activity.

It is clear that action is needed to break the cycle of adolescent pregnancy and childbearing. All teens need access to comprehensive health and sexuality education programs that enable them to make mature choices about sexual activity. Those adolescents who do become sexually active need access to reliable contraceptive methods. Teens who are especially at risk need outreach and life options counseling, while those who are pregnant and parenting need prenatal care, support to finish school and information and motivation to avoid repeat pregnancies.

Most of all, young women and men need to feel they have a productive place in society. They need opportunities to be personally validated in ways other than becoming a parent. Life options courses that combine sexuality education, decision-making skills, future planning and community services have been shown to reduce rates of teen pregnancy.

If adolescent pregnancy is to be effectively addressed, it must be viewed in a broad context. Economic and educational solutions are needed that decrease poverty, unemployment and school failure. Family support is needed so parents will have the time and energy to spend with their children as well as the skills to communicate openly about sensitive topics such as pregnancy and sexually transmitted diseases.

According to Marian Wright Edelman of the Children's Defense Fund, "the best contraceptive is a real future." Punishing adolescent parents by reducing public assistance benefits or removing their children will not provide any incentive to improve their lives, and only threatens their future. Teen parents need support, not censure, in order to overcome the very real obstacles they face and to develop into mature, productive adults who are capable of effective parenting.

Part 1—

Overview of Adolescent Pregnancy in Missouri

Adolescent pregnancy remains a serious issue in Missouri in the 1990s. High pregnancy and birth rates are creating a generation of young parents who are ill-equipped to meet the demands of their role. It is encouraging that 1993 data is beginning to show a decrease in teen births. However, levels remain too high to be complacent, and further data are needed to establish a significant trend.

African-American teens are at much higher risk for becoming parents, and virtually none of their children will be born into two-parent households. In addition, a greater proportion of births to African-American adolescents are to 15 to 17 year olds, who are less mature and too often unprepared for the role of parenthood.

The data also suggests that teen pregnancy, poverty and school success are linked, and that we cannot effectively impact teen pregnancy unless we also address the other two realities.

The availability of adequate prenatal care remains a concern. About half of the Missouri counties with high teen birth rates appear to provide adequate health services to their youth, lowering the risk of low birthweight infants. Some counties with low birth rates are not reaching their few teen parents, resulting in elevated levels of high-risk births.

Each county needs to examine the relevant teen pregnancy issues and develop specific strategies that will work in their communities.

> ***"I have two children myself. I have one that's just turned four, and one that's almost a year. I just, like, you know, have them."***
>
> —Denise, 17

Adolescent Pregnancies and Births Remain at High Levels

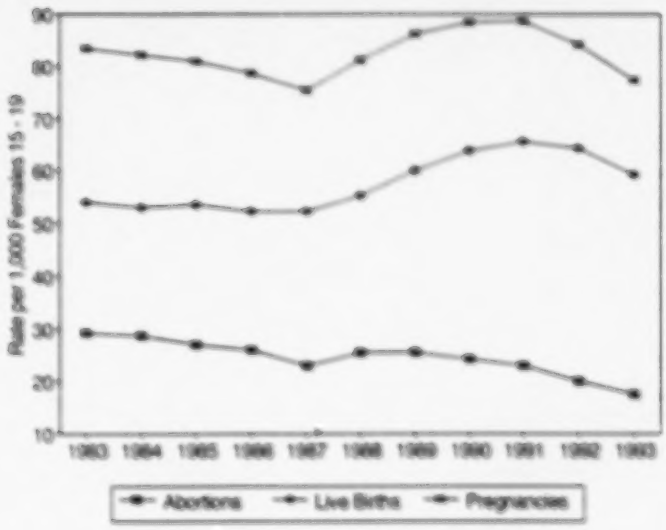
There were almost 14,000 teen pregnancies in Missouri in 1993. The *pregnancy rate* for 15 to 19 year old females decreased from 83.6 per 1,000 in 1983 to 75.5 in 1987, but rose after that point to a high of 88.8 in 1991.[1] Data for 1993 indicate a decrease in the pregnancy rate to 77.3 (*see Figure 1*).

These numbers do not tell the entire story in Missouri. Because current state laws mandate parental consent for teen abortions, some experts believe that the pregnancy rate is underestimated. A certain number of teens go out of state to have abortions and are not included in the official state count. It is difficult to estimate the true pregnancy rate, but it may be as much as 20% higher than the records indicate.

[1]Unless otherwise indicated, "adolescent" indicates youth ages 15 to 19.

Figure 1

Missouri Adolescent Pregnancies, Abortions and Births —1983-1993



The limited data available indicate that the ***abortion rate*** in Missouri decreased during the 1980s, from 29.2 per 1000 adolescent females in 1983 to 17.4 in 1993. The percentage of adolescent pregnancies that end in abortion decreased from more than one-third to less than one-quarter. Some of this decline may be related to increased difficulties in obtaining an abortion due to laws requiring parental consent and decreased availability of public funding. Abortion also became an increasingly controversial issue during the 1980s. Young girls who have conflicting emotions about their pregnancies might be less likely to have an abortion, given the negative images presented to them. A third factor affecting the downward abortion trend might be related to teens' expectations for their future. Research has shown that teens who have high educational and employment expectations are more likely to have an abortion because they see a greater personal cost to childbearing. The decrease in adolescent abortions might be an indicator that fewer teen girls can clearly visualize such a future.

An average of 29 Missouri teens gave birth each day in 1993. There were 10,657 live births to teens in 1993, or 14.2% of the total births in Missouri. The adolescent ***birth rate*** declined from 54.0 per 1,000 adolescent females in 1983 to 52.2 in 1987, and then increased to 65.5 in 1991. The birth rate in 1993 was 59.5. While births to teens have decreased, the birth rate has yet to reach the lower levels of the mid 1980s.

An alarming trend among adolescents has been the percentage of births to unmarried teens. While ***unmarried teens*** accounted for slightly more than half (53.9%) of all teen births in 1983, by 1993 three-quarters (75.4%) of all teens giving birth were unmarried. Because at least half of all children living in single parent families are poor, the high rate of unmarried teen mothers indicates high levels of poverty and welfare dependence for these young girls and their children.

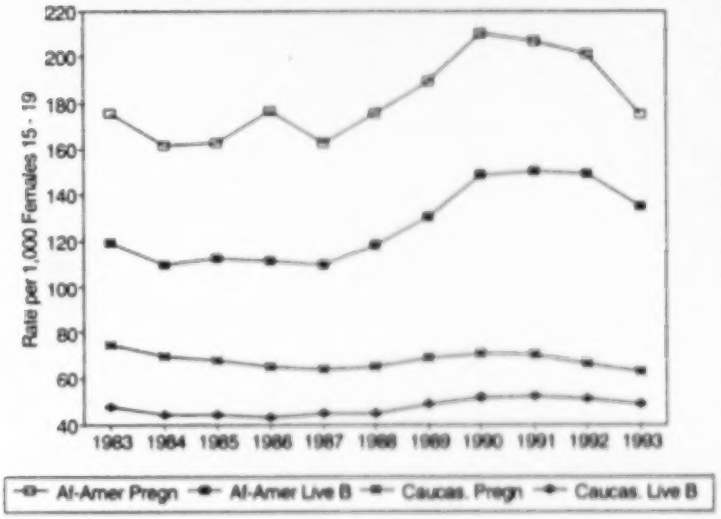
The majority of teens who give birth are beginning new families; very few of their infants are placed for adoption. Nationally, only three percent of Caucasian teens and less than one percent of African-American teens relinquished custody of their babies in 1982-88, compared to nineteen percent and two percent respectively in 1965-72. Although research on the determinants of adoption is limited, some studies have linked the likelihood of relinquishing to high levels of educational aspiration and socioeconomic status.

African-American Teens Face Much Higher Risks for Pregnancy and Birth

While two-thirds of the teen births in 1993 were to Caucasian females, African-American teens face much higher risks for becoming adolescent parents than their Caucasian peers (see Figure 2). The pregnancy rate for African-American girls ages 15 to 19 was almost three times the rate for Caucasians in 1993 (175.3 per 1,000 females; vs 62.9). The percent of pregnancies that ended in abortions was similar for African-Americans (23%) and Caucasians (22%). The birth rate for African-American teens in 1993 was also almost three times that of Caucasian teens (135.0 per 1,000 females vs 48.7).

Figure 2

Missouri Adolescent Pregnancies and Births By Race—1983-1993



For African-Americans, teen birth and unmarried teen birth are virtually synonymous. Almost all (97.9%) of the 3,364 births to African-American teens in 1993 were to unmarried females, while approximately two-thirds (64.9%) of Caucasian teens giving birth were unmarried.

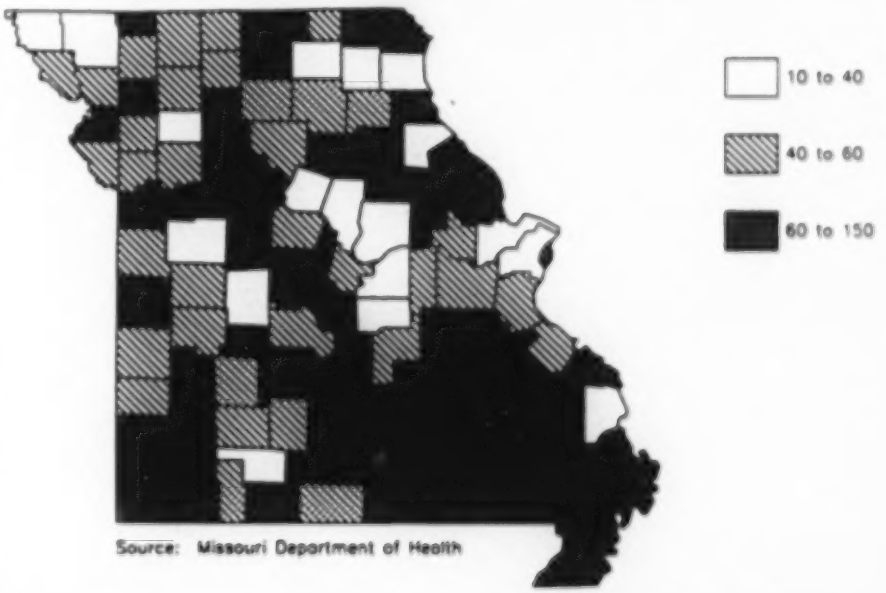
Regional Comparisons Indicate Link Between Pregnancy and Poverty

The Missouri counties with the highest rates of teen birth in 1993 were primarily in urban and southeast Missouri: Pemiscot, St. Louis City, Mississippi, Reynolds and Dunklin (see Figure 3). Four of these five counties had extremely high rates of children living in poverty, and ranked lowest overall in the 1993 KIDS Count Report which rated

African-American adolescents are more likely to become pregnant at an earlier age. The pregnancy and birth rates for all 18 to 19 year old adolescents in 1993 were approximately two and one-half times those of the rates for 15 to 17 year olds. However, approximately 43% of African-American teen births are accounted for by young adolescents, compared to 33% for Caucasians.

Figure 3

Missouri Adolescent Birth Rates by County Per 1,000 Females 15-19, 1993



counties on 12 measures of children's well-being.

The counties with the lowest teen birth rates were primarily in north and central Missouri: Osage, Nodaway, Adair, Maries and Atchison.

Females who do not receive adequate prenatal care are about three times more likely to deliver low birthweight babies. Half or more of teen mothers in Mercer (83.3%), Osage (75%), Worth (75%), Daviess (61.5%), Reynolds (52.2%) and Ripley (51.4%) counties did not receive adequate care (see Figure 4).

Low birthweight infants account for two-thirds of all infant deaths. They are two to three times more likely to have disabling conditions. Seventeen Missouri counties had no low birthweight babies born to adolescents in 1992. However, more than one in six infants was born weighing less than 5.5 pounds in the rural counties of Cedar, Ralls, Adair, Atchison and Monroe.

Urban Areas Are Challenged to Respond to Adolescent Pregnancy on a Large Scale

Missouri's three urban counties (Jackson, St. Louis City and St. Louis County) accounted for 41% of all adolescent births. There were almost 1,700 births to adolescents in St. Louis City in 1993, and almost all (97.2%) were to unmarried teens. St. Louis City, in addition to high rates of unmarried teen births, had high levels of inadequate prenatal care and low birthweight infants. Over four in ten adolescents received inadequate prenatal care, and one in eight infants were born with low birthweight. St. Louis County ranked 16th in adolescent birth rates, with three in ten adolescent births receiving inadequate prenatal care, one in twelve infants born with low birthweight and almost nine in ten adolescent births to unmarried mothers. Jackson County ranked 82nd in adolescent births. Three in ten of its adolescent mothers did not receive adequate prenatal care and approximately one in ten babies were born with low birthweight. Unmarried adolescents accounted for 85.6% of all adolescents giving birth.

The primary goal of this report is to provide data so communities can improve local strategies to address the problems of teen pregnancy. Limited statistical analysis of the 1993 data suggests that in the 16 Missouri counties with populations of at least 2000 females aged 15-19, there is a strong correlation between the rate of live births per 1000 teens and the percent of adolescents aged 16-19 who are not in school and not in the labor force. This relationship becomes very strong when the percent of children in poverty in the county is also considered in a multi-variate analysis. There is a moderate relationship between high rates of live births and low rates of students completing high school. The population in these 16 counties accounts for two-thirds of the total Missouri female population aged 15-19.

Missouri Adolescent Birth Rates and Risk Indicators by County—1993

COUNTY	Live Births	Birth Rate/1,000 Rate	Birth Rate/1,000 Rank	% Inad. Prenatal Care Rate	% Inad. Prenatal Care Rank	% Low Birthweight Rate	% Low Birthweight Rank	% Unmarried Percent	% Unmarried Rank
ADAIR	**29**	**16.4**	**3**	**37.9**	**99**	**17.2**	**112**	**69.0**	**79**
ANDREW	25	51.0	38	20.0	46	4.0	25	60.0	57
ATCHISON	**6**	**24.7**	**5**	**0.0**	**1**	**16.7**	**111**	**83.3**	**110**
AUDRAIN	53	73.8	83	26.9	67	3.8	23	66.0	71
BARRY	**85**	**72.7**	**77**	**37.5**	**97**	**10.8**	**86**	**55.4**	**46**
BARTON	18	58.1	50	33.3	87	5.6	40	33.3	5
BATES	**38**	**87.4**	**106**	**34.3**	**90**	**7.9**	**62**	**63.6**	**36**
BENTON	15	34.8	12	6.7	8	0.0	1	60.0	57
BOLLINGER	**31**	**86.6**	**104**	**35.5**	**94**	**6.5**	**46**	**38.8**	**10**
BOONE	160	26.1	6	30.9	78	16.3	110	81.3	109
BUCHANAN	**231**	**82.9**	**96**	**42.9**	**106**	**5.2**	**36**	**78.2**	**102**
BUTLER	97	74.3	84	43.3	107	8.2	65	54.6	44
CALDWELL	**8**	**31.9**	**9**	**0.0**	**1**	**12.5**	**95**	**75.0**	**99**
CALLAWAY	44	31.9	10	38.1	100	11.4	90	72.7	89
CAMDEN	**43**	**58.0**	**49**	**19.5**	**45**	**4.7**	**32**	**51.2**	**3**
CAPE GIRARDEAU	104	38.3	17	19.2	43	1.9	18	65.4	69
CARROLL	**22**	**62.7**	**61**	**18.2**	**36**	**0.0**	**1**	**54.5**	**43**
CARTER	15	80.6	91	28.6	71	6.7	48	60.0	57
CASS	**125**	**52.7**	**40**	**16.5**	**26**	**4.8**	**33**	**74.4**	**96**
CEDAR	22	64.3	64	9.1	13	22.7	115	40.9	19
CHARITON	**12**	**50.8**	**37**	**25.0**	**62**	**8.3**	**66**	**50.0**	**28**
CHRISTIAN	50	38.0	15	26.0	66	10.0	79	56.0	49
CLARK	**15**	**61.7**	**59**	**16.7**	**28**	**13.3**	**99**	**73.3**	**92**
CLAY	216	40.7	22	24.8	61	6.8	67	72.7	88
CLINTON	**25**	**43.4**	**27**	**29.2**	**72**	**12.0**	**93**	**68.0**	**77**
COLE	85	40.6	21	32.9	86	9.4	75	87.1	113
COOPER	**21**	**49.1**	**35**	**19.0**	**41**	**14.3**	**102**	**66.7**	**72**
CRAWFORD	46	69.6	73	17.4	33	15.2	107	63.0	66
DADE	**19**	**86.8**	**105**	**11.1**	**16**	**0.0**	**1**	**31.6**	**2**
DALLAS	36	64.5	101	19.4	44	13.9	101	61.1	61
DAVIESS	**14**	**82.8**	**39**	**61.5**	**112**	**7.1**	**55**	**71.4**	**86**
DE KALB	21	95.5	108	38.1	100	9.5	76	57.1	51
DENT	**40**	**84.6**	**102**	**10.0**	**14**	**10.0**	**79**	**45.0**	**23**
DOUGLAS	23	61.3	56	17.4	33	4.3	27	56.5	50
DUNKLIN	**130**	**107.2**	**111**	**27.3**	**68**	**13.1**	**98**	**65.4**	**69**
FRANKLIN	137	46.1	31	17.8	35	6.6	47	74.5	95
GASCONADE	**22**	**54.5**	**44**	**13.6**	**20**	**4.5**	**30**	**50.0**	**26**
GENTRY	8	41.0	23	0.0	1	12.5	95	37.5	15
GREENE	**380**	**41.6**	**24**	**16.6**	**27**	**7.9**	**62**	**61.1**	**60**
GRUNDY	16	44.0	29	18.8	38	6.3	43	62.5	63
HARRISON	**12**	**52.9**	**41**	**25.0**	**62**	**0.0**	**1**	**33.3**	**6**
HENRY	36	58.7	51	8.3	10	2.8	20	52.8	38
HOLT	**8**	**47.3**	**33**	**25.0**	**62**	**12.5**	**95**	**62.5**	**65**
HOWARD	12	35.0	13	27.3	68	0.0	1	66.7	72
HOWELL	**87**	**81.5**	**93**	**12.6**	**19**	**6.9**	**51**	**44.8**	**21**
IRON	35	85.4	103	11.8	18	11.4	91	37.1	14
JACKSON	**1,470**	**73.8**	**82**	**29.5**	**74**	**11.0**	**88**	**65.6**	**111**
JASPER	226	69.8	74	32.1	82	11.9	92	58.4	53
JEFFERSON	**271**	**43.9**	**28**	**16.9**	**31**	**7.0**	**53**	**74.9**	**98**
JOHNSON	73	29.8	8	24.3	59	6.8	50	46.6	27
KNOX	**5**	**37.0**	**14**	**40.0**	**102**	**0.0**	**1**	**80.0**	**108**
LACLEDE	65	72.1	75	14.3	21	9.2	72	44.6	20
LAFAYETTE	**57**	**62.4**	**60**	**33.9**	**89**	**5.3**	**37**	**66.7**	**72**
LAWRENCE	85	84.1	99	18.8	38	10.6	85	55.3	45
LEWIS	**14**	**26.2**	**7**	**21.4**	**52**	**7.1**	**54**	**71.4**	**85**
LINCOLN	66	68.6	69	32.8	85	7.6	60	75.8	101
LINN	**22**	**57.7**	**47**	**31.8**	**81**	**4.5**	**30**	**36.4**	**12**
LIVINGSTON	30	72.5	78	10.3	15	13.3	99	70.0	81
MCDONALD	**58**	**104.6**	**110**	**21.1**	**51**	**10.3**	**84**	**44.8**	**21**

Missouri Adolescent Birth Rates and Risk Indicators by County—1993

COUNTY	Live Births	Birth Rate/1,000 Rate	Birth Rate/1,000 Rank	% Ined. Prenatal Care Rate	% Ined. Prenatal Care Rank	% Low Birthweight Rate	% Low Birthweight Rank	% Unmarried Percent	% Unmarried Rank
MACON	**27**	**55.9**	**45**	**42.3**	**105**	**14.8**	**106**	**59.3**	**55**
MADISON	27	77.1	88	18.5	37	0.0	1	59.3	55
MARIES	**5**	**17.4**	**4**	**40.0**	**102**	**0.0**	**1**	**80.0**	**106**
MARION	56	64.0	63	30.9	78	14.3	102	62.5	63
MERCER	**6**	**57.1**	**46**	**83.3**	**115**	**0.0**	**1**	**33.3**	**4**
MILLER	46	66.5	67	34.9	92	2.2	19	73.9	93
MISSISSIPPI	**58**	**120.8**	**113**	**23.2**	**55**	**6.9**	**51**	**69.0**	**79**
MONITEAU	26	63.0	62	38.0	95	3.8	24	50.0	28
MONROE	**16**	**64.8**	**66**	**33.3**	**87**	**18.8**	**113**	**68.8**	**78**
MONTGOMERY	20	61.2	55	31.6	80	5.0	34	65.0	68
MORGAN	**33**	**72.8**	**79**	**15.6**	**24**	**3.0**	**22**	**63.6**	**67**
NEW MADRID	63	84.1	100	37.7	98	14.3	102	73.0	91
NEWTON	**121**	**75.2**	**87**	**35.1**	**93**	**7.4**	**58**	**48.3**	**26**
NODAWAY	19	14.3	2	5.3	6	5.3	37	52.6	36
OREGON	**23**	**66.5**	**67**	**21.7**	**53**	**4.3**	**27**	**30.4**	**2**
OSAGE	4	9.6	1	75.0	113	0.0	1	75.0	99
OZARK	**16**	**59.9**	**52**	**18.8**	**38**	**6.3**	**43**	**50.0**	**28**
PEMISCOT	124	149.4	115	34.7	91	9.7	77	80.6	108
PERRY	**34**	**61.7**	**58**	**23.5**	**57**	**2.9**	**21**	**79.4**	**105**
PETTIS	82	73.5	81	16.7	28	7.3	56	57.3	52
PHELPS	**53**	**41.7**	**25**	**20.8**	**50**	**7.5**	**59**	**58.5**	**54**
PIKE	37	74.6	86	32.4	83	10.8	87	73.0	90
PLATTE	**88**	**41.9**	**26**	**24.4**	**60**	**6.8**	**49**	**71.6**	**87**
POLK	39	40.2	20	20.5	47	10.3	83	38.5	17
PULASKI	**111**	**78.8**	**90**	**20.7**	**49**	**9.9**	**78**	**53.2**	**41**
PUTNAM	11	78.6	89	0.0	1	9.1	69	36.4	12
RALLS	**10**	**33.8**	**11**	**30.0**	**76**	**20.0**	**114**	**40.0**	**18**
RANDOLPH	60	80.9	92	32.7	84	10.0	79	66.7	72
RAY	**43**	**60.0**	**53**	**23.3**	**56**	**9.3**	**73**	**55.8**	**48**
REYNOLDS	25	108.7	112	52.2	111	16.0	109	36.0	11
RIPLEY	**43**	**97.1**	**108**	**51.4**	**110**	**9.3**	**73**	**34.9**	**9**
ST CHARLES	287	38.7	18	25.3	65	4.5	29	76.7	103
ST. CLAIR	**13**	**50.4**	**36**	**7.7**	**9**	**0.0**	**1**	**46.2**	**24**
STE GENEVIEVE	21	40.2	19	14.3	21	0.0	1	85.7	112
ST. FRANCOIS	**106**	**61.4**	**57**	**17.0**	**33**	**11.3**	**89**	**75.5**	**84**
ST LOUIS	1,167	38.3	16	30.5	77	8.1	64	89.7	114
SALINE	**63**	**82.7**	**95**	**19.0**	**41**	**6.3**	**45**	**74.6**	**97**
SCHUYLER	6	46.9	32	0.0	1	0.0	1	33.3	5
SCOTLAND	**9**	**68.7**	**70**	**44.4**	**109**	**0.0**	**1**	**55.6**	**47**
SCOTT	109	74.5	85	22.6	54	10.1	82	70.6	83
SHANNON	**17**	**69.4**	**72**	**5.9**	**7**	**5.9**	**41**	**52.9**	**39**
SHELBY	9	44.1	30	11.1	16	0.0	1	33.3	5
STODDARD	**82**	**63.7**	**60**	**27.8**	**70**	**6.1**	**42**	**52.4**	**38**
STONE	34	53.5	42	29.4	73	14.7	105	70.6	82
SULLIVAN	**13**	**73.0**	**80**	**15.7**	**29**	**7.7**	**61**	**61.5**	**62**
TANEY	54	61.2	54	24.1	58	7.4	57	53.7	42
TEXAS	**49**	**69.2**	**71**	**16.3**	**25**	**4.1**	**26**	**53.1**	**40**
VERNON	44	57.8	48	29.5	74	15.9	108	77.3	104
WARREN	**33**	**53.7**	**43**	**36.4**	**96**	**9.1**	**69**	**66.7**	**73**
WASHINGTON	73	90.6	107	15.1	23	5.5	39	74.0	94
WAYNE	**33**	**82.3**	**94**	**41.9**	**104**	**9.1**	**69**	**51.5**	**34**
WEBSTER	39	47.9	34	20.5	47	5.1	35	28.2	1
WORTH	**4**	**72.7**	**78**	**75.0**	**113**	**0.0**	**1**	**50.0**	**28**
WRIGHT	45	93.6	97	8.9	12	8.9	68	37.8	16
ST. LOUIS CITY	**1,672**	**137.2**	**114**	**43.3**	**107**	**12.4**	**94**	**87.3**	**113**

*For counties with fewer than 20 births, rates and ranks are unstable and should be interpreted with caution.

1 = lowest 115 = highest

Part 2—

Risk Factors for Adolescent Pregnancy

National data indicate both sexual activity and contraceptive use among adolescents is on the rise. Increasing rates of sexual activity make it imperative that teens at risk be identified and targeted for appropriate services. Several factors that are linked to higher rates of adolescent pregnancy have been identified, including poverty, lack of parental involvement, and school failure. Experiencing sexual abuse as an adolescent appears to put girls at higher risk for sexual activity and pregnancy.

> ***"We weren't using protection, because I was scared to go to my mother. We did use condoms, and it burst. It was like an off-and-on thing. We used them sometimes, sometimes we didn't. I was seven weeks pregnant when I found out."***
>
> —Natalia, 16

Teen Sexual Activity and Contraceptive Use Are Both Increasing

Teen pregnancy cannot occur without sexual activity and the failure of or failure to use contraception. While there are no data regarding the sexual activity of Missouri adolescents, national studies indicate that the percent of 15 to 19 year olds who are sexually active has increased steadily over the past 30 years. It is estimated that 29% of this age group was sexually active in 1970. By 1988 more than half of women and almost three-fourths of men had intercourse before their 18th birthday *(see Figure 5)*. Most of the increase in female sexual activity during the 1980s occurred among Caucasian teens from higher income levels.

Teens are becoming sexually active at an earlier age as well. In 1988, 30% of girls had experienced sex by age 15, compared to 18% in 1982. This is a critical figure, because the younger teens start having sex, the less likely they are to use contraception and the more severe the impact of pregnancy on their lives.

Contraceptive use in the U.S. has increased. Over half of teens reported using no contraception for their first intercourse in 1982, while

Figure 5

Adolescent Sexual Activity Rates 1958-1988

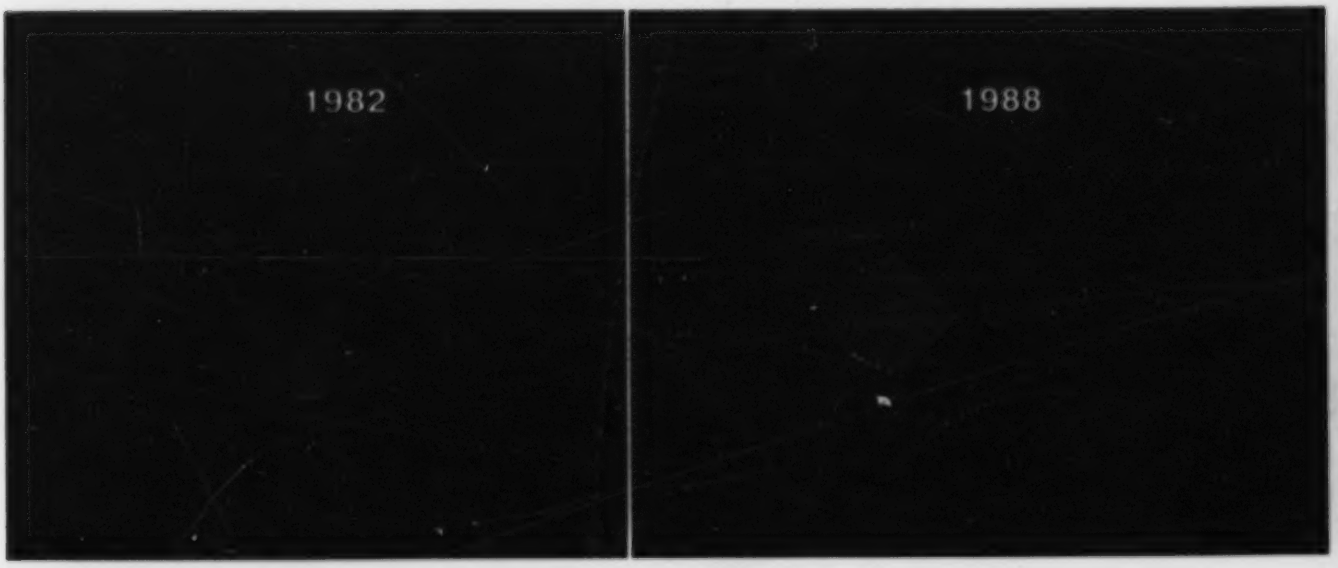
slightly over one third used no contraception in 1988 *(see Figure 6)*. Almost three-quarters (72%) of teens aged 15-17 and 84% aged 18-19 reported using a contraceptive on an on-going basis. Because contraceptive use has improved, national data actually indicate a steady decline in the adolescent pregnancy rate among sexually experienced women since 1980.

Condom use among adolescents doubled during the 1980s; the percent of teens who use them regularly increased from 23% to 48%. Teens who use other methods of birth control must also use condoms to protect themselves from sexually transmitted diseases and HIV infection, as this age group is extremely vulnerable to sexually transmitted diseases (STDs). An estimated 3 million adolescents get STDs each year, accounting for 25% of all new cases annually. In 1993, one-third of all STD cases reported in Missouri were to 15 to 19 year old youth. STD rates are of particular concern for the St. Louis area, which ranks at or near the top of all major metropolitan areas in syphilis and gonorrhea rates.

Teens who utilize over-the-counter contraceptives such as condoms also need to be seen by

Figure 6

Adolescent Contraceptive Use at First Intercourse



health professionals for periodic STD screening. However, only about two-fifths of adolescents seek medical contraceptive services within their first year of sexual activity. Family planning clinics are the most common source of medical services, used by two-thirds of women aged 15 to 19.

Those who don't use any contraceptives are playing a dangerous game of Russian Roulette with pregnancy. Approximately one-quarter of teens who don't use contraceptives become pregnant within six months of initiating sexual activity. About half will become pregnant within two years. One-fifth of all teen pregnancies occur in the first month following the initial sexual activity. According to the Alan Guttmacher Institute (AGI) 1994 report, teens who do use the pill or condoms are almost as successful as older women in preventing unwanted pregnancies.

Risk Factors for Teenage Pregnancy Provide Basis for Strategies

■ Poverty

In Missouri and across the nation, teens who live in poor households are more likely to become pregnant and give birth. More than half of 15-19 year olds who gave birth in 1988 had incomes less than the federal poverty level. Living in a single-headed family and having parents with low levels of education, or a mother or sibling who was a teen mother also increases the risks for youth.

■ High Risk Behaviors

Engaging in high risk behaviors increases the likelihood of sexual activity in young teens. The AGI's survey indicated that of the 14-15 year olds who were sexually active, 87% reported regularly using marijuana, 69% regularly smoked cigarettes, and 66% regularly used alcohol.

The likelihood of being sexually active also increases if the teen has boy or girl friends who already have had intercourse.

■ Poor academic skills

Educationally, teens who are most likely to become pregnant are those who have low school grades, low educational goals, and a tendency toward truancy. Poor basic academic skills are also a strong predictor of teenage pregnancy. The National Longitudinal Survey of Young Americans showed that almost all racial differences among teens for pregnancy rates disappeared when the factors of income and academic skills were controlled. In the study, one in five poor teens, regardless of race, with lower than average basic skills was a teenaged mother, compared to one in twenty nonpoor teens with average or better basic skills.

■ Media

While it is difficult to establish a causal link between sex in the media and teen births, it is apparent that teenagers are bombarded with images of sex with few corresponding messages of responsibility or restraint. It is estimated that there are approximately 14,000 sexual references on television annually, and that only one percent of these deal with topics such as sex education, contraception, abortion or sexually transmitted diseases. The vast

"Before I got pregnant, I felt that, yes, I could bring a child into this world. But after he got here, I felt that, you know, this is something I should have really thought about what I was doing, because I brought a child in this life who I have to care for and who have to depend on me for everything. The one thing about having kids out of wedlock, is it will never be the same. Your whole teen age life . . . you will not have one."

—Charlie, 17

majority (94%) of sex shown on today's soap operas involves people not married to each other. Given these role models, it is no wonder that teens romanticize sex and do not consider the realities.

■ Sexual Abuse

Another factor that is starting to be understood is the relationship between sexual abuse and teenage pregnancy. Polit found that sexually abused teenaged girls were more likely to engage in voluntary sexual intercourse than girls who had not experienced sexual abuse. The prevalence of involuntary sex among young teens is appalling. The AGI reports that 74% of adolescents who had intercourse before age 14, and 60% who had intercourse before age 15, reported having had sex involuntarily. In a study of 535 teen mothers in Washington State, two-thirds reported being sexually abused or molested. Adolescents who had been sexually victimized were more likely to have had sex at an early age and to have used drugs or alcohol during their first sexual experience than those who had not.

"All the 'Just Say No' pregnancy prevention programs wouldn't have made a bit of difference. Saying no was the last thing I could have done. The only way I could have avoided getting pregnant was to get out of my house, and I was too afraid to ask someone to help me do that." - Margaret, became pregnant as a result of sexual abuse at age 13.

Positive Relationships with Family and Church Can Reduce Risk

Parental and spiritual involvement during the often difficult adolescent period are factors that reduce risk. Adolescents are at a difficult crossroads in their lives and often experiment with high risk behavior in their search to define themselves. Despite their need to separate themselves from their parents, teens who have a high level of support, communication and monitoring from their parents are less likely to become pregnant. Teens who find structure or support from religious or community involvement are also less at risk.

Part 3—

Consequences of Adolescent Childbearing

Both adolescent mothers and their children are vulnerable to economic, health and educational difficulties. Younger mothers are less likely to receive adequate prenatal care and to deliver normal birthweight babies. Many will experience a repeat birth while they are still in their teens. Their educational, employment and economic prospects are poor, with the result that their children are likely to grow up in a poor household and have poor educational outcomes themselves. Many will become part of a generational cycle of adolescent pregnancy and motherhood. Adolescent pregnancy is a tremendous cost to society, in terms of public support and lost productivity.

"After I had my son, it was like, you know, you have somebody now to set an example for. It hasn't set me back. It has made me strive."

—Natalia, 16

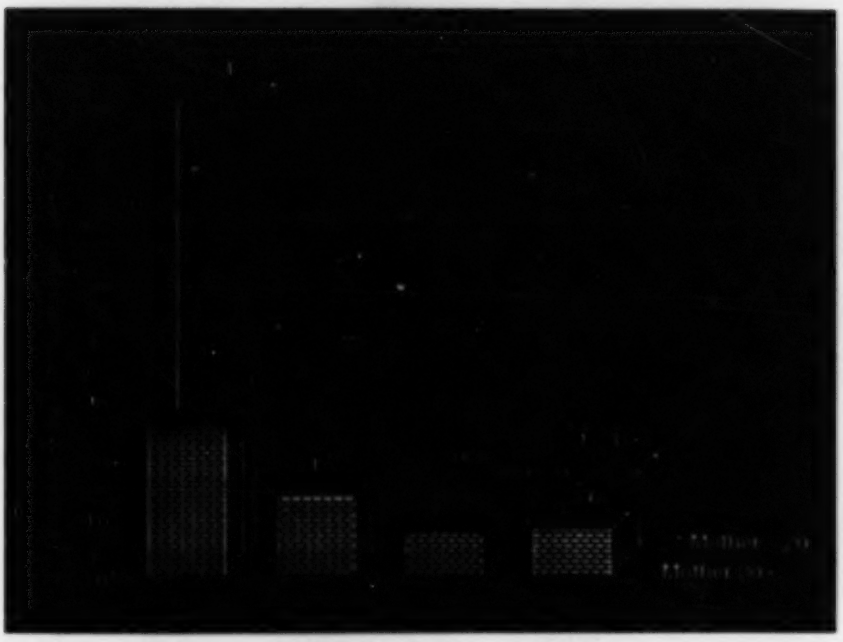
Adolescent Mothers Face Increased Health, Economic and Educational Risks

Teen pregnancy takes an enormous toll on our youth and society. Teen mothers face greater health risks than older mothers, such as anemia, pregnancy-induced hypertension, toxemia, premature delivery, mortality and cervical trauma. Many of these health risks are due to inadequate prenatal care and support, rather than physical immaturity. In Missouri, 29.6%, or over 3,000 teen mothers received inadequate prenatal care in 1993, as opposed to 13% of mothers over the age of 20 *(see Figure 7)*. Four in ten pregnant African-American teens did not receive sufficient health care. Although still at an unacceptable level, the percent of teens receiving adequate prenatal care has increased since 1983 from 63.4% to 70.4%

While adolescent parents are no longer automatically expected to drop out of school, 80% do. Only half of those who have their first child before age 17 will graduate from high school by age 30, and 70% will complete high school by age 39.

Figure 7

Selected Pregnancy Risk Indicators by Age 1993



A few years can make a great difference in the life of a teen mother. A woman who gives birth between the ages of 20-24 is almost twice as likely to complete college as one who gives birth at age 19 or younger.

Teens without a high school diploma are likely to face a lifetime of economic stress. Women who began their childbearing as teens earn half of the income of women who became mothers after the age of 20. Receipt of child support is rare for adolescent mothers. Only one in ten never-married teen mothers receive the child support due them. When teen mothers marry, their husbands are three times less likely to have completed high school than their peers, and have higher unemployment rates.

Many teen mothers are living in poverty at the time of their infants' births. Of the Missouri teen births in 1993, 78% were to females covered by the Medicaid program, compared to 33% of births to older women. Almost four in ten (38%) of the young mothers received food stamps.

Teen mothers have higher than average numbers of children, and their children are spaced more closely together than those of older mothers. One in four Missouri teen births in 1993 was ***not*** a first birth. It is possible to envision that teens with adequate support could overcome the stresses of having one child, go on to finish school and find meaningful, well-paying employment. However, it is almost impossible to believe that the burdens of single parenthood and the demands of more than one child could be as easily addressed. Repeat births also send an alarming signal that appropriate family and life planning services are not reaching teen parents.

Children of Teen Parents Start Their Lives at a Disadvantage

The children of teen parents too often become part of a cycle of poor health, school failure and poverty. Infants born to teen mothers are at higher risk of prematurity, fragile health, need for intensive care, cerebral palsy, epilepsy and mental retardation. In Missouri, 9.3%, or almost 1,000 of the infants born to adolescents had low birthweights (less than 5.5 pounds), compared to 7.2% of those born to older mothers. The infant

mortality rate for infants of teen mothers was 12.4 per 1,000 live births in 1993, compared to 7.6 for older mothers. Children whose mothers are age 17 or younger are three times as likely to be hospitalized.

Children of teen mothers are four times more likely than their peers to be poor, and are likely to stay poor for a longer period of time.

> ***"I want to see my kid grow up and not make the same mistakes that I did. I want her to be smart and not think on her ass."***
>
> —Carla, 18

The children born to teen mothers consistently score lower on measures of cognitive development than the children of older mothers. It appears that rather than declining over time, educational deficits increase in severity and the children show lower academic achievement, higher dropout rates, and are more likely to be retained.

The teen pregnancy/parenting cycle is likely to be repeated. Children of teen parents start sexual activity earlier than their peers and are more likely to become teen parents themselves. Nationally, half of mothers who had their first child as teens had at least one daughter who became a teen parent. This compares to one-quarter of those who were over 20 when they had their first child.

Economic Costs of Teen Pregnancy

Nationally, half of the women receiving AFDC began receiving benefits as teenagers. Approximately three in ten teen mothers go on welfare within three years of the birth of their first child, compared to 20% of all women who become single mothers. In Missouri, 7.9%, or almost 6,600 of AFDC enrollees for April 1994 were females ages 19 or younger.

A 1989 Center for Population Options study estimated that, in St. Louis City, $81 million of the amount spent on AFDC, Food Stamps and Medicaid was directly attributable to teen childbearing. The study estimated a potential savings of $32 million had these teens waited to have children. Nationally, the Center estimated a potential savings of $10 billion in 1990 if mothers had delayed their childbearing until at least age 20.

These figures are not intended to become part of the current rhetoric of "welfare reform" that blames welfare recipients and accuses them of draining our tax dollars. If adequate services, including job training, education, employment opportunities, health care and child care, were in place for these families, they would have better options than joining the welfare rolls. The Center for Population Options study estimates that for every $1 of federal funds spent to provide contraceptives to women, $4.40 is saved. This is money that would otherwise be needed for medical care, welfare and nutrition programs in the two years following the birth. If we choose to invest in our youth, the investment will pay off in the long run.

Part 4—

Principles and Strategies to Reduce Adolescent Pregnancy

In order to have an impact on the adolescent pregnancy issue, action is needed at multiple levels. First, specific programs that target adolescent sexuality, contraceptive use and pregnant or parenting teens are needed. However, it is unlikely that these programs will have a long-range impact unless the underlying issues of poverty, unemployment and school success are addressed as well. Programs that revive distressed neighborhoods, improve schools and give youth a future will have the best chance of reducing at-risk behavior by adolescents—including juvenile crime, substance abuse ***and*** *adolescent pregnancy. Interventions must also address the parents or other significant adults in the adolescents' lives to foster improved communication regarding sexuality, contraceptive use and pregnancy decisions. Programs need to target the family, not just the at-risk teen.*

Delaying Sexual Activity

The "Just Say No" message of the 1980s failed to have a significant impact on teens, as evidenced by the increase in pregnancy and birth rates in the second half of the decade. Pretending that abstinence is the only choice for teens and then closing our eyes to the consequences is not a productive approach. Similarly, traditional sex education classes that only present information about reproductive functioning and contraceptive use have not proven to be effective. Recent studies found an extremely weak correlation between students' knowledge of birth control and their consistent use of it.

Programs that are likely to be successful in convincing teens to delay sexual activity start in early adolescence, by the sixth or seventh grade at the very latest. They are interactive classes that provide youth with information about sexuality and birth control, and then take the additional step of helping them develop skills to make decisions, be assertive, and resist pressures to have sex. They also discuss influences that promote sexual activity, involve a high level of role modeling and provide opportunities to practice the skills taught.

Unfortunately, on average, middle and senior high schools in the U.S. offer six and one-half hours per year on all sexuality education topics, and less than two hours on contraception and the prevention of sexually-transmitted diseases. In Missouri, there is no requirement for either sex or HIV education. Missouri's state-prepared curricula has been rated "inadequate" and the preparation of its sexuality teachers "poor" by the Sex

Information and Education Council of the United States.

Encouraging Contraception Use

Sexually active adolescents are often uninformed, unrealistic and confused about contraception. They may fear that their parents will find out if they try to obtain birth control and may not trust traditional service providers. Communication between partners is often poor, and many girls feel that it is "unromantic" to anticipate sex by acquiring contraception. If they don't prepare for it, they can claim it was just "something that happened," and perhaps lessen the guilt of having intercourse.

> ***"Sex education never helped because I never read it. You can talk and talk and talk, and the mind of a teenager is going to always do what he or she wants to do."***
>
> —Natalia, 16

Programs that offer contraceptive services are most effective when they follow the "three C's" of convenience, cost, and confidentiality. After-school or weekend hours, reasonable costs and a guarantee of confidentiality are the first steps toward attracting adolescents. But it is not enough to be available to teens—programs must provide outreach to high risk groups and must employ staff who are comfortable with adolescents.

The most important predictor of contraceptive use is the satisfaction with the method. Many of the current birth control options available are not well-suited for teens. Birth control pills are not ideal for teens who may have episodic sexual encounters and who don't plan ahead well. The pills' side effects also deter use. Diaphragms are unpopular with teens not yet comfortable with their own bodies. Norplant and Depo-Provera are recent contraceptive methods that require only periodic intervention. However, both cost and side effects may limit their utilization. The bottom line, however, is that the majority of teens are using contraceptives; use of condoms and other forms did increase during the 1980s. No one method is best for teens. In addition to helping teens make the initial selection to fit their lifestyle, frequent contact and follow-up is needed to ensure that teens are satisfied with their selection and that they continue to use birth control.

Helping Pregnant and Parenting Teens

It is critical to ensure that pregnant adolescents receive timely prenatal care, in order to reduce the chances of low birthweight, infant mortality and other health complications to which they are vulnerable. Unfortunately, there are many barriers to overcome, including inadequate or no health insurance, lack of transportation, lack of child care, the teenager's own ambivalence or denial about pregnancy, and mistrust of health care providers. Outreach and follow-up are again crucial. Programs for pregnant and parenting teens that are comprehensive—with integrated education, employment, child care and health services—are most effective. Programs should also focus on parenting skills and the postponement of subsequent births.

Adolescent Pregnancy is a Male Problem Too

Too often the discussion about adolescent pregnancy revolves exclusively around the teen girl. While it is true that the impact of becoming a parent will be much more severe on her than on the father, males are not unaffected by the event.

Male partners of sexually active adolescent girls are, on average, about three years older. While most do not remain in committed relationships with the mother of their child, their involvement with their child is higher than stereotypes allow. Public/Private Ventures' Young Unwed Fathers Pilot Project, located in Philadelphia, found that 75% of the program participants visited their child in the hospital when he or she was

born. Approximately one-quarter lived with their child and/or the child's mother. Four in ten who did not live with their children reported seeing them almost every day and 70% had seen them at least once a week. More than half of the fathers reported involvement in activities such as bathing, feeding, dressing and playing. While few (30%) had child support orders, almost 90% reported providing some monetary support despite generally poor economic and employment situations.

Because males are slightly older, they may have greater developmental ability to make responsible decisions regarding sexuality and contraceptive use. While there are far fewer programs targeted specifically for males than females, there have been some successful programs that work to change male attitudes. These help young men to realize how they are socialized to act in certain ways that see impregnating women as a positive, "macho" accomplishment. Many of these programs are combined with male mentoring to present positive role modes. Two North Carolina programs (Mantalk and Wise Guys) that use mentors and peer leaders, have been at least preliminarily successful in changing young males' knowledge, attitudes and behaviors. The Public/Private Ventures program combines job training, education, support, follow-up and "fatherhood development" services.

In many traditional health service facilities, males are treated in a hostile manner by a frequently all-female staff. More male-friendly service providers are needed. Males also need to feel that they have rights as well as responsibilities when it comes to sexuality, contraception and parenting. Finally, providing young boys with constructive activities and hope for the future may decrease their high-risk behavior.

Holistic Approaches to Reduce Teen Pregnancy

If we are going to make a difference in the lives of teens, we must provide them with constructive alternatives to sex and violence. A small but growing number of "life options" programs are developing in schools and in communities. These programs follow the adage of Marion Wright Edelman, who said, "The best contraceptive is a real future." In addition to sexuality and contraceptive education, these programs provide support services that enable teens to plan for their futures so they have a reason to say no to sex and pregnancy. These programs include vocational guidance, educational support, and health care. They are often long-term and family-focused, recognizing that work with the teenager's family is a crucial component.

> ***"When I lived on the streets, in my stupid crazy days, I got a girl pregnant. And I was 13 then, so the baby would probably be about three years old right now. I would like to see the baby. I'm really mad at myself now, cause, like I said, I never wanted to have kids until I was absolutely sure of what kind of parent I'd be. But at that time, I wasn't really thinking of the future. I was just a person who was mad at the world and just do whatever the heck he felt like."***
>
> —Patrick, 17

At an even broader level, efforts are needed that reduce poverty and improve schools. We must also provide education and support so parents can be positive role models for their adolescents, communicate with them regarding their developing sexuality, and have active involvement in their lives. Basic health care must become more accessible and attractive to teenagers. Adolescents, caught somewhere between pediatricians and adult family doctors, spend the least amount of time with physicians per visit than any other age group.

Adolescents are in an uneasy transition between childhood and adulthood. Structured activities, especially community service opportunities, can give adolescents a taste of adult responsibilities and a chance to feel they are making a positive contribution to society. In addition to increasing self-esteem and hope for the future, these activities decrease the time spent home alone. It is estimated that at least 30% of eighth graders are home alone more than two hours per day after school, and risky behaviors exhibit a noticeable increase at or above this level.

Most of all, there must be a public commitment to our youth and to reducing teen pregnancy and other negative behaviors. A variety of providers from both traditional and nontraditional sectors must become involved, and collaboration among organizations must occur to ensure a wide range of comprehensive services. It's not always easy to love teenagers; their struggle for independence can make them seem like difficult toddlers with drivers' licenses. In order to secure the future of the next generation - and the next - and to end the cycle of teen pregnancy and poverty, we must embrace them and help them develop productive futures.

Part 5—
Selected Missouri Programs That are Making a Difference

The following is not meant to be an exhaustive list of programs for adolescents in Missouri. Citizens for Missouri's Children contacted, by mail and telephone, approximately 50 organizations and asked them to submit abstracts for pregnancy prevention programs and programs for pregnant or parenting adolescents. We found that it was much easier to identify programs for pregnant or parenting teens than to find programs that delivered prevention services. It is possible that we did not target the appropriate organizations. However, it is also likely that there are few prevention programs in existence, given the tendency to put more money into crisis intervention than prevention.

CMC was also interested in highlighting programs that had evaluated their own success and had shown to improve outcomes, such as adolescent pregnancy or receipt of prenatal care. Again, we found that few organizations had performed such evaluations. While we understand the budgetary and personnel limits these organizations are working with, we encourage all service organizations to include outcome-based evaluation in their process. With financial resources being scarce, funders are demanding more and more accountability from the agencies they sponsor, and evaluations are becoming increasingly more important.[1]

Increasing Parent-Child Communication to Promote Responsible Behavior

Research shows that youth whose parents served as their primary source of sexuality education demonstrate more respectful and responsible sexual attitudes and behaviors. The Family Guidance Center's **Parent-Child Sexuality Education** program aims to strengthen the parent-child relationship and to facilitate the family's communication on the topic of sexuality. Courses are designed for youth and their parents. Boys and girls of ages 9 to 12 and 13 to 15 each have separate curricula. Classes consist of twenty persons (10 parent-child pairs) and include group activities, videos, mini-lectures, discussions and games. Topics covered include reproductive anatomy and physiology, reproduction, pregnancy, childbirth and parenthood. The older adolescents and their parents also discuss dating relationships, birth control, sexually transmitted diseases and teenage pregnancy. All classes include a focus on personal responsibility, communication, decision-making and relationship-building skills.

[1]The Children's Trust Fund publishes an excellent evaluation manual that can be useful to organizations trying to develop an evaluation process. For a copy, contact CTF at (314) 751-5147.

The program, which is located in St. Joseph, began in 1976. Approximately 350 to 400 individuals are served each year. The Parent-Child Sexuality Education program has been evaluated by an independent research firm, which found that participants experienced an increase in sexual knowledge and in clarity of values. Parent-child communication regarding sexuality also increased. Since the initiation of the program in the nine-county catchment area, a distinct downward trend in teen pregnancy has been noted. The program has received national attention for its unique and successful teaching approach. A published curriculum with course outlines, mini lecture guides, activities and games, video resources and tips for introducing the program in the community is available.

Teen-to-Teen Theater Enables Peers to Address Consequences of High-Risk Behavior

Created in 1992, **interACT Teen-to-Teen Theater** is a company of teen actors from high schools and middle schools in the Columbia area. The program is sponsored by the City of Columbia, Planned Parenthood of Central Missouri and corporate gifts. interACT develops and performs short plays dealing with a variety of teen issues, such as peer pressure, teenage pregnancy, eating disorders, sexually transmitted diseases and HIV/AIDS. The short plays, written by the teens, have unresolved, open-ended conclusions, allowing audience participation to resolve the issues. The program's goals are to foster family communication about sensitive subjects, deliver medically accurate information and promote healthy, responsible decision-making.

The target groups for interACT are youth ages 13 to 19. Performances are held at churches, schools, social service agencies, malls and other public places. interACT also serves several four-year colleges and universities, targeting freshmen and sophomores who are at a transitional period in their growth and development.

The program is based on the belief that teens have difficulty thinking about the consequences of their actions and learn primarily through their own actions. The opportunity for teens and their parents to practice and rehearse life skills without risking the consequences is one of the program's strengths.

While no formal evaluation of the program has been done, pre and post-tests are given to both actors/peer educators and the audience. These indicated that interACT participants have shown increased knowledge, change in attitude and planned behavior.

Targeting High-Risk Siblings of Teen Parents

The Children's Mercy Hospital's Adolescent Health Clinic operates the **Choices Affect Life (CAL)** and **Mothers of Mothers (MOMs)** programs. CAL targets young girls whose older sisters or mothers became pregnant at a young age. These girls are statistically at higher risk for the same outcomes. The program provides a learning experience in which these teens can develop the positive self-image and decision-making skills to enable them to plan for their futures.

The girls, ages 11 through 15, participate in a 7-session curriculum. Presentations are participatory, with minimal classroom-style education. Topics include self-image, feelings, future planning, decision-making, facts of life, and substance use. The program, located in Kansas City, is a cooperative venture of the Adolescent Clinic and the Beta Omega Chapter of Alpha Kappa Alpha Sorority Inc. Trained volunteers and clinic support staff facilitate the groups. Participants are identified when they are seen at the clinic or their sisters are seen at the Teens Mom group at the hospital. Transportation for participants is provided to the hospital.

The mothers of the CAL participants are invited to three education sessions of their own, called the MOMs group. A volunteer and professional from the clinic work with the mothers around issues of communicating about sexual activity, birth control, and pregnancy with their daughters.

Urban Prevention and Intervention Program

The **Back to Basics** program, part of the Urban League's Health Improvement Project, serves 480 middle-school aged youth and their parents per year. The program's goal is to prevent pregnancies by educating youth to make informed choices. The program consists of two six-month sessions per year with ten workshops per session. Groups meet every other Saturday. Topics include self-esteem, health and hygiene, responsible sexual behavior, AIDS education, STDs, substance abuse and gangs. In addition, Back to Basics provides basic academic skills to children so they can build on what they learn in school. Each session also includes two recreational activities.

Back to Basics works with parents by providing a support system, inviting them to the sessions, and providing home visits. While the program serves youth from throughout the City of St. Louis, there is a large focus on North St. Louis because of the high rate of pregnancies.

Community-Based Collaboratives Address Variety of Prevention and Intervention Needs

The **Beginnings Project**, sponsored by the University of Missouri Extension, consists of 22 separate projects in counties throughout the state. The projects strengthen the ability of the communities to directly meet the complex and varied needs of their pregnant and parenting adolescents. Seed money is provided to develop a coalition of interested agencies and local leadership to address issues of teen pregnancy, and to leverage additional funding. Each coalition completes a community assessment process and develops a proposal for an intervention that they determine best meets the needs of their communities. Proposals must include a plan for program evaluation.

The projects initiated provide adolescents with a variety of services, such as life skills, support groups, mentoring programs, resource directories, counseling and child day care. Pemiscot County has implemented a Beginnings project called Project Advance. This program emphasizes life skills and continuing education. Monthly meetings, a support network and incentives for enrolling in a post-high school program all contribute to help pregnant and parenting teens become successful parents and self-sufficient individuals. In Butler County the Beginnings project, Teenagers as Parents (TAP), aims to decrease repeat pregnancies, encourage education and career planning, and improve parenting skills. TAP meetings piggyback to the monthly Women Infants and Children (WIC) programs in the county.

School-Based Program for Pregnant and Parenting Adolescents

St. Louis Public Schools' **Parent/Infant Interaction Program (PIIP)** provides educational services and support services for pregnant and parenting adolescents, encouraging them to remain in school until graduation. Approximately 650 to 700 students are served per year. The program's components are:

- **Project Redirection—**
  includes parenting, child management and career education classes; recruitment and training of volunteer role models; counseling and case management.

- **CRIB/Infant Toddler Day Care Center—**
  prevents dropout by providing on-site day care for students during their classes.

- **Male Involvement Component (MIC)—**
  involves male parents in as many components of PIIP as possible, such as Parenting Skills, Career Education and Child management. A special class addressing the unique issues of male teen parents is facilitated by selected professionals.

- **Comprehensive Opportunities for Positive/Parenting Experiences (COPE)—** (funded by the Danforth Foundation) designed to sensitize school based teams and staff to the needs of pregnant and parenting students. COPE also helps staff make needed changes in attitudes and behaviors to enable them to better meet the needs of adolescent parents.

The program is evaluated each year for its ability to increase school attendance, improve classroom achievement, increase understanding of various contraceptive methods and delay second pregnancies.

Support for Homeless Teen Parents

Mother's Refuge, located in Independence, operates two shelters for homeless pregnant and parenting adolescents. It has served approximately 52 clients per year since 1988. Mother's Refuge East provides services for pregnant adolescents, who are admitted anytime during their pregnancy and remain for six to eight weeks following delivery. Mother's Refuge West is a longer-term residence for adolescents and their children, where clients can live for as long as two years.

The program's goals are to reduce infant mortality and morbidity rates, and to provide support so adolescent mothers can transition into adult living. Support services provided to clients include access to medical care, individual/group counseling, food, clothing, educational and/or job training, childbirth/parenting classes, life skills, and independent living skills. Both facilities are always full and usually have waiting lists.

The majority of Mother's Refuge residents have at some point in their lives been victims of physical and/or sexual abuse. The residents themselves are involved in a peer education program, visiting area schools and talking to other students to dispel myths about the "joys" of teen pregnancy. They share their stories honestly in hopes of discouraging other teens from repeating their mistakes.

Comprehensive Community Health Services for Pregnant Teens

Swope Parkway Health Center's **Community Health Project** aims to prevent low birthweight among pregnant, low-income African American teens and reduce the incidence of poor pregnancy outcomes. The Project, located in inner Kansas City, is an intensive social service model which locates women early in pregnancy and assures adequate prenatal care and social service support. The program then follows up on infants through their first year in order to instruct mothers in infant care, provide social services as needed and encourage regular medical visits for the infant.

The project team works with participating organizations, social service agencies, schools and churches to contact young women who have not entered prenatal care. Transportation is provided to the Health Center, where women receive prenatal/infant nutritional counseling, individual and group counseling, educational presentations and assistance locating and using additional services as necessary.

The program serves approximately 3,000 girls per year and has been in operation since 1985. The infant mortality rate for Community Health Project patients in 1990-93 was 4.3 per 1,000, compared to 17.1 for the entire service area. The low birthweight rate was 2.5%, compared to 9.1% for the service area.

Resource Mothers Help Teen Mothers

The **Resource Mothers Program** of Whole Health Outreach in Ellington and **Mothers Asking Mothers (MAM) Program** of Grace Hill Neighborhood Health Center in St. Louis utilize similar methods. Volunteers, who are mothers with a history of successful parenting, are trained to act as mentors, support and friends to preg-

nant and parenting teens. Through home visits, teen mothers receive support, education, and access to community services. The volunteers may also provide transportation, help with problem solving, assist with child care or day-to-day errands.

Because the volunteers are lay members of the community, adolescents may feel more comfortable with them than with traditional health care providers. The MAM program serves 200 to 250 women per year in St. Louis. Resource Mothers operates in rural Carter, Iron, Reynolds and Wayne Counties and has served approximately 100 women in its first year of operation.

Specialized Family Education for Teen Parents

The Parents as Teachers program, offered by every Missouri school district, operates a special project for teen parents. The goals of the **Teen Parents as Teachers** program are to empower teen parents, give their children a solid foundation for school success, increase parents' feelings of competence and confidence, improve parent-child interaction, increase parents' knowledge of child development and reduce child abuse. The program is offered statewide.

PAT for teen parents is often connected with the local high school, which allows for optimum accessibility for pregnant and parenting teens in peer support group meetings. The home visit component offers an individualized approach allowing for a one-on-one relationship between the parent educator and young parent. Developmental screenings for children and linkage with community resources are also provided through PAT.

Program evaluation reports indicate that the program has been linked to an increase in the number of teen parents' children who are developmentally on target, an increase in the number of teen parents remaining in school, and an increase in birth weight of infants born to teen parents.

Collaborative Life Options Program for At-Risk and Pregnant Teens

The **Teen Opportunities to Achieve in Life (TOTAL) Collaboration** will begin operation in Fall of 1994. It is an ambitious collaboration of the Junior League of St. Louis, National Council of Jewish Women, Ferguson/Florissant School District, North County Service Coalition, St. Louis County Health Department, Metroplex Inc. and St. Louis Regional Medical Center. Together with several other collaboration partners, TOTAL will improve community resources and provide a range of health and social services.

The program is being piloted in a north St. Louis County school district that includes areas with high rates of poverty, child abuse, unemployment and teen pregnancy. The two major elements are:

- **TOTAL Team—**
  an after-school weekly program for middle school and first year high school students. The curriculum is based on the nationally recognized Teen Outreach Program (TOP), a life options program. TOP combines small group experiences, tutoring and community service to build self-esteem, decision-making ability, and academic skills.

- **TOTAL Case Management—**
  serves pregnant and parenting teens and their families by encouraging high school completion and discouraging repeat pregnancies. Each teen will be assigned a case manager to coordinate health and family services. Participants will also be provided with a mentor, tutoring, and health/life skills education.

TOTAL has set forth measurable outcomes it wishes to achieve, including:

- 85% of pregnant or parenting teens enrolled in case management will complete their schooling either through formal education or high school equivalency;
- 95% of pregnant teens will receive prenatal care and will deliver babies with a minimum birth weight of 5.5 pounds.

During the first year of operation, 15 students will be served through the TOTAL Team and a minimum of 30 through the TOTAL Case Management. A comprehensive evaluation will be implemented.

Appendix I—

Missouri Program Contacts

- **Parent Child Sexuality Education Program**
  Family Guidance Center/CMHC
  910 Edmond
  St. Joseph, MO 64501
  (816) 364-1501
  Jean G. Brown, Vice President
  Family Health Services

- **interACT Teen-to-Teen Theater**
  Planned Parenthood of Central Missouri
  711 North Providence Road
  Columbia, MO 65203
  (314) 449-2475
  Rick J. Plummer, Ph.D.

- **Choices Affect Life (CAL)**
  Adolescent Health Clinic
  Children's Mercy Hospital
  2401 Gillham Road
  Kansas City, MO 64108
  (816) 234-3050
  Pat Palmer, M.S.W.

- **Back to Basics**
  Urban League of Metropolitan St. Louis
  3701 Grandel Square
  St. Louis, MO 63108
  (314) 289-0309
  Brenda Cain-Ray
  Director of Health Education Program

- **Beginnings Project**
  University of Missouri Extension
  162B Stanley Hall
  University of Missouri at Columbia
  Columbia, MO 65211
  (314) 882-6687
  Michelle Wells, RN, Project Coordinator

- **Parent/Infant Interaction Program (PIIP)**
  Pupil Personnel Services
  St. Louis Public Schools
  Vashon High School
  3405 Bell Avenue
  St. Louis, MO 63106
  (314) 531-9028
  Dr. Mildred R. Anderson, Supervisor

- **Mother's Refuge**
  3721 Delridge
  Independence, MO 64052
  (816) 353-8070
  Sue Emslie, House Administrator

- **Community Health Project**
  Swope Parkway Health Center
  4900 Swope Parkway
  Kansas City, MO 64130
  (816) 923-5800
  Ivy Ganaway, Director

- **Mothers Asking Mothers (MAM)**
  Grace Hill Neighborhood Health Center
  2600 Hadley Street
  St. Louis, MO 63106
  (314) 241-2200
  Sharon Wagner, Program Coordinator

- **Resource Mothers Program**
  Whole Health Outreach
  Route 3, Box 11E
  Ellington, MO 63638
  (314) 663-7117
  Sister Rita Schonhoff, Developer
  Karen Sanders, Coordinator

- **Teen Parents as Teachers**
  Parents as Teachers National Center
  9374 Olive Boulevard
  St. Louis, MO 63132
  (314) 432-4330
  Karen Hoelker, Teen Parent Specialist

- **TOTAL Collaboration**
  c/o Junior League of St. Louis
  10435 Clayton Road
  St. Louis, MO 63131
  (314) 569-3117
  Karen Goodman and Cindy Garrison, Co-Chairs

Appendix 2

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Source for Missouri data, unless otherwise indicated, is Missouri Department of Health, Division of Health Resources.

Source for data on Missouri AFDC recipients is Missouri Department of Social Services, Research and Evaluation Unit.

Infant mortality rate—number of deaths to infants under one year of age per 1,000 live births.

Percent of births with inadequate prenatal care—percent of births where mothers received fewer than five prenatal visits for pregnancies less than 37 weeks, fewer than eight visits for pregnancies 37 weeks or longer or care beginning after the first four months of pregnancies.

Percent low birthweight infants—percentage of live births recorded as low birthweight. Babies of low birthweight are those who weight under 2,500 grams (5.5 pounds) at birth.

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Research Associate, *Tanna Klein*
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Photos by ***Christine Coco*** and ***Joseph Johnson***

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2717 Sutton Avenue
St. Louis, MO 63143
(314) 647-2003
Fax (314) 644-KIDS